MAP-813D
(R. 7/3/06)

Cabinet for Health and Family Services
Department for Medicaid Services

BREAST & CERVICAL CANCER TREATMENT PROGRAM
REQUEST FOR EXTENSION

RECIPIENT'S NAME: _____

RECIPIENT'S IDENTIFICATION #: _____

RECIPENT'S DATE OF BIRTH: _____/_____/_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

A.

SHE IS RECEIVING TREATMENT FOR:
□ BREAST CANCER
□ CERVICAL CANCER
□ PRECANCEROUS CERVICAL OR BREAST DISORDER

B.

RECIPIENT'S MEDICAL AND TREATMENT HISTORY (PLEASE INCLUDE INDICATIONS AND RATIONALE FOR TREATMENT, I.E. PREVENTATIVE, CURATIVE, PALLIATIVE)_____
_____
_____
_____
_____
_____
_____
_____

NEW TREATMENT END DATE: _____/_____/_____

PHYSICIAN'S SIGNATURE: _____
DATE: _____

TELEPHONE #: (_____)_____-_____ FAX #: (_____) _____ - _____

_____
AGENCY USE ONLY
MA END DATE HAS BEEN CHANGED TO: _____/____/_____

ELIG. POLICY STAFF SIGNATURE: _____ DATE: _____

ELIG. MAINT. STAFF SIGNATURE: _____ DATE: _____